MONTANA
Department of Public Health & Human Services

Internet - rev. 9/9/2005

Montana CHIP
Children's Health Insurance Plan

PO Box 202951, Helena MT 59620-2951 • E-mail: chip@mt.gov • WebSite: www.chip.mt.gov
1-877-543-7669 (Free call) • FAX: 1-877-418-4533 (Free call)

CHIP provides health insurance benefits to children less than 19 years of age who don't have other health insurance. Household income must meet CHIP income guidelines. Benefits include well-child visits, prescription drugs, limited dental care, eyeglasses and many other services. Some families pay a small co-payment when services are used.

CHIP reviews each application for the programs listed below. If it appears your child might qualify for another program, we will forward your application to the program. Children who qualify for Medicaid cannot have CHIP.

For more information, contact CHIP at the numbers or addresses above.

Medicaid

Medicaid provides excellent health benefits for children. Well-child visits and other medically necessary services are provided. Children may be covered up to their 19th birthday.

Families must meet income and asset guidelines. There are no co-payments. In some cases, Medicaid may even pay past medical bills.

If it appears your children may be Medicaid eligible, CHIP must forward your application to your local Office of Public Assistance (OPA). We also send you a short Medicaid application. You must complete the short application, include the requested documentation and mail it to the OPA. If you do not provide this information to the OPA, your children cannot be insured by Medicaid or CHIP.

Children's Special Health Services (CSHS)

CSHS assists families by paying medical costs and finding other assistance. CSHS also holds clinics for care and treatment of children with special health needs. Examples of covered conditions are asthma, diabetes, cleft lip or palate, cystic fibrosis, heart conditions, seizures, etc.

If you have a child with a special health condition and would like us to forward your application to CSHS, please complete the following.

_____

Child's name Condition

Children's Mental Health Services Plan (CMHSP)

CMHSP pays for additional health services for children who have a severe emotional disturbance. Families must meet income guidelines. If you have a child with a mental health diagnosis and would like us to forward your application, please complete the following. If you appear to be eligible, they will contact you for additional information.

_____

Child's name Treatment Provider

Start applying here!

Information about

Applicant Name: E-mail address:

Mailing Address: City & Zip

Phone numbers: Home Work Other

2 List the following people, if they are living in your home more than 50% of the year. (attach separate sheet, if necessary)

✓ **Yourself** ✓ **Your spouse** ✓ **Children's other parent** ✓ **Children**

Name - first, middle initial, last	**What is this person's relationship to you**	**Social Security Number** required for children	**Date of birth** Month/Day/ Year	**Age**	**Gender** (M or F)	**US Citizen** required for children (Y or N)	**Montana Resident** (Y or N)	*(Optional)* **Race** (include all that apply - American Indian, Asian, Pacific Islander, Black, White, Hispanic)
	Applicant (self)							

List anyone in the home attending pre-school through the 12th grade: _____

List anyone in the home who is in college or a university: _____

Is anyone listed above pregnant? If yes, list her name and due date: _____

3 Assets

Not counting the value of the home you live in and one vehicle, does the equity value of all other assets you own total more than $3,000? Equity value means the market value of the asset minus any money you owe on the asset. Below are just some types of assets.

- real property (do not count the value of the home you live in)
- vehicles, snowmobiles, camp trailers, etc, (do not count the value of one vehicle)
- liquid assets such as checking or savings accounts, certificates of deposit (CDs), cash, etc.

❑ **Yes. My family has assets over $3,000.** ❑ **No. My family does not have assets over $3,000.**

4 Care for children and disabled or elderly adults

If anyone in the household pays for care while adults in the home work or are in school, complete the following:

Person(s) receiving care	**Name of person giving care**	**Amount paid**	**How often do you pay**

5 Household Income (attach separate sheet if necessary)

Fill out the income tables below. CHIP uses the income you list on this application to estimate your family's yearly income. List all income currently received or expected for the next 12 months.

You do not need to attach proof of income to this application. We ask a random sample of CHIP-qualified families to confirm the income shown on their application. If chosen, we will send a letter about 2 weeks after you receive notice that your children qualify for CHIP.

Employment - List all members of your home who work. List full-time, part-time, seasonal, and temporary jobs, tips, commissions received or expected. Include unemployment received or expected under the Other Income Section below.

Name	Name of employer	Start date	Average hours worked per week	Pay or wages per hour	If you earn tips, average tips earned per week	If this job is seasonal, weeks or months worked per year
			If hours/pay vary, give a range (example, 20-30 hours a week)			

Self-Employment and Rental Income and Expenses - Self-employment means you are your own boss. List business income and expenses received or expected.

Name	Business name	Start date	Yearly income before expenses	Yearly depreciation expense (if any)	All other yearly business expenses

Other Income - List income received or expected by all household members, including children. Including, but not limited to, the types of income listed below. **When amount or fequency (frequency) varies, please provide a range e.g., $100 to $500 weekly or 3 to 6 payments yearly.**

- child support and alimony
- Social Security Disability or Retirement (include the total amount before Medicare premium is taken out)
- Social Security Survivor's Benefits
- Supplemental Security Income (SSI)
- unemployment insurance
- pensions, retirement or 401 K income
- railroad retirement or disability
- interest, dividend or CD income
- royalties or leases (mineral, grazing, etc.)
- Worker's Compensation
- military allotments
- foster care payments
- veteran's benefits
- subsidized adoption payments
- government payments on land

Name	Type of income	Amount received	How often is this amount received?

Information about people living elsewhere

List all members of the household who are temporarily living elsewhere (for example, living with relatives, in a hospital, etc).

Name:_____ Where are they living?_____

Name:_____ Where are they living?_____

Health Insurance

To qualify for CHIP, a child must be without health insurance for at least 3 months. Please tell us if your children had or are losing insurance. There are reasons the 3 month waiting period can be waived.

- Have any children listed above been covered by health insurance (individual or group) during the 3 months prior to this application? If yes, fill in below and include the date and reason insurance ended. Reasons might include:
  - parent laid off or fired
  - parent has new job
  - parent's employer stopped coverage
  - coverage too expensive
  - parent can no longer work because of disability
  - premium increased too much

Name of child	Name of insurance company	Insurance end date	Reason insurance ended

- List children whose parent or step-parent (including parents not living in the home) works for the State of Montana or the Montana University System

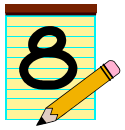
_____

- List children who may have health insurance, other than CHIP, within the next 12 months.

_____

- Do you or your spouse have insurance? (This is for reporting only. It will not be used to determine your children's eligibility.)

You: Yes ❑ No ❑ **Spouse:** Yes ❑ No ❑



I understand if my CHIP-enrolled child moves within or out of Montana or gets other health insurance coverage, I must report these changes within 10 days of my knowing about them. Call (toll-free) 1-877-543-7669.

If requested, I must provide proof that my children are eligible for benefits. I may receive help in gathering documents or contacting individuals or agencies by calling 1-877-543-7669.

I know the information I have given may be reviewed and verified by State of Montana staff. I also understand that I must cooperate fully with state and federal staff if my case is reviewed. By signing this application, I give my permission for the State of Montana to obtain verification and information necessary to determine my children's eligibility.

I know the information I have given is confidential. I agree that information about my children may be released only if needed to administer CHIP. I understand that the information on this application will be forwarded to those programs listed on the cover of this application if my family meets the program guidelines.

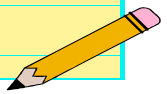
I understand that I may request a review of any decision made. Send written requests for review to Children's Health Insurance Plan, PO Box 202951, Helena, MT 59620-2591.

I understand this application will be considered without regard to race, color, gender, age, disability, national origin, religion, marital status or political belief. I understand that if I believe I have been discriminated against, I may file a complaint with the Civil Rights Coordinator, Human and Community Services Division, Department of Public Health and Human Services, PO Box 202952, Helena, MT 59620-2952.

Signature - Please print and sign this application, then submit to the address below. Please make a copy for your records.

- ✓ I certify that the information I have given is true to the best of my knowledge.
- ✓ If I knowingly give false information to enroll my children in CHIP, I understand that I must reimburse CHIP for any costs incurred.
- ✓ I understand my children will be disenrolled from CHIP if they have other creditable health insurance.

Signature Of Applicant _____ Date _____



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